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ABSTRACT

This document is one of seven publications contained in a series of materials for physicians on recognizing, intervening with, and treating adolescent alcoholism. The materials in this unit of study are designed to make the physician aware of resources available for use when working with an adolescent alcoholic or substance abuser. The constraints faced by the physician as decisions are made are explored and physicians are urged to explore their own attitudes and beliefs and their affect on the decision-making process. This unit of study will enable the physician to: (1) describe the services available to assist the physician in the treatment of adolescent alcoholism and substance abuse; (2) identify the levels of treatment available for adolescent alcoholism; (3) list indicators for each level of treatment; (4) describe services available to families and how assistance can be given to the family in using appropriate services to meet their needs; (5) compare and contrast various issues involved in treatment decisions from the points of view of the adolescent, the family, and the physician; and (6) develop specific listings of services available in one's community to assist in the treatment of adolescent alcoholics and to provide support and guidance for the families of adolescent alcoholics. (NB)

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Adolescent Alcoholism: Recognizing, Intervening, and Treating

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Adolescent Alcoholism: Recognizing, Intervening, and Treating

5 The Physician's Role in Referral and Treatment

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Introduction

The treatment and/or decisions made by physicians as they treat adolescent alcoholics are crucial to the health and well-being of both the adolescents and their families. Such decisions often differ from treatment and referral decisions made in relationship to other disease processes in that technical competence is only one of the parameters which must be considered. Also of importance are such factors as cost, since insurance often does not cover services, and psychological and social support systems associated with the selected treatment process, since not only the adolescent but also the family generally becomes involved in the treatment process. The location of treatment is important, particularly as a case requires inpatient or outpatient services. This unit of study examines the parameters involved in the treatment and referral process and provides guidelines for physicians as they endeavor to make appropriate treatment and referral decisions.

Goal

The goal of this unit of study is threefold. First, the physician will be made aware of the variety of resources to draw upon as treatment for the adolescent alcoholic or substance abuser is sought. Second, the unit of study explores the constraints faced by the physician as decisions are made. Finally, physicians are urged to explore their own attitudes and beliefs and how these attitudes and beliefs may impinge upon the decision-making process.

Objectives

Upon completion of this unit of study, you will be able to:

1. *Describe, in general terms, the services available to assist the physician in the treatment of adolescent alcoholism and substance abuse.*
2. *Identify the levels of treatment available for adolescent alcoholism.*
3. *List indicators for each level of treatment.*
4. *Describe services available to families and how assistance can be given the family in using appropriate services to meet their needs.*
5. *Compare and contrast various issues involved in treatment decisions from the points of view of the adolescent, the family, and the physician.*
6. *Develop specific listings of services available in one's community to assist in the treatment of adolescent alcoholics and to provide support and guidance for the families of adolescent alcoholics.*

Overview

The physician must answer several key questions for each individual patient prior to making a treatment recommendation.

You have met with an adolescent patient in your office, and you have sufficient data to be concerned about the possibility of an alcohol or other drug problem. Perhaps you are not totally convinced that a problem with chemicals exists. Or, perhaps, the evidence is so overwhelming that you know that something must be done to help this adolescent. Perhaps you have already contacted the adolescent's family and expressed concern to them; now they are looking to you for guidance. You may be planning to talk informally with the adolescent and the family in your office, or perhaps you are planning a full-scale formal intervention.

Regardless of your approach, at this point there are several questions which must be answered before you proceed. They are:

- How do I best help this family/adolescent in trouble with chemicals?
- Am I capable of treating the adolescent and the family myself in my office?
- Do I want to send them for treatment elsewhere? If so, where do I send them?
- How do I know which resources are best suited to the needs of adolescents and their families?
- How do I know if a treatment program is providing quality services?

These are not easy questions to answer. A physician who wants to be knowledgeable concerning adolescent chemical dependency treatment resources must take the time to investigate what is available in a particular community and in surrounding areas. This is not always an easy task. However, it is a critical one in light of the complexity of this disease and the desirability for early intervention. The material presented in this unit of study is intended to present guidelines for physicians who wish to become knowledgeable of treatment resources in the community for adolescent chemical dependency.

The Best of All Possible Worlds: Continuum of Care

Locating Resources

Availability of treatment services varies widely. Information about such services may be obtained from telephone directories, newspapers, local alcohol abuse agencies, and appropriate national organizations.

There is a tremendous variability from one part of the country to another in the availability of services for the treatment of the chemically dependent adolescent. Some physicians may be fortunate to practice in a large metropolitan area where an entire spectrum of services may be available. Others may live in rural areas or small towns where they may be fortunate if there is a group of Alcoholics Anonymous to which to refer the adolescent. Physicians in such service-deprived areas may need to look longer and harder to find appropriate services, but the result will be well worth the effort. If a physician is convinced that alcohol and other drug addiction in adolescents is a treatable primary disease, then finding and recommending appropriate treatment resources becomes not a matter of choice, but one of necessity. The following offers some suggestions for the physician who is engaged in a search to find resources for an adolescent patient.

Telephone Directories

Historically, starting at the national level with the National Institute on Alcohol Abuse and Alcoholism and with the National Institute on Drug Abuse, funding efforts, and therefore treatment efforts, for alcoholism and drug abuse have been separated. This divided approach has filtered down into many states and localities that receive funds from the Federal Government. In actual practice, however, most treatment providers today see individuals who are typically dependent both on alcohol and other drugs; therefore, the terms "chemical dependency" and "chemical dependence" have evolved. Nevertheless, the vast majority of the general public still views alcohol and drug addiction as being different. Therefore, in response to the public's perception, most telephone directories are organized with two separate headings, one for alcoholism and another one for drug abuse. Most persons using the yellow pages to locate services for the chemically dependent adolescent would be apt to look under these headings rather than under a chemical dependence heading.

Newspapers

Many newspapers, especially large city newspapers, may run advertisements for alcohol and other drug treatment services in the surrounding areas. While the same many not be true of small town newspapers, they often will publish the weekly meetings of self-help groups in the area. In one sense, this is an advantage to the small town or rural physician. Physicians in large metropolitan areas do not have the advantage of weekly listings of self-help group meetings since there are so many meetings that it would be impossible to publish them on a daily basis.

Information Services

Large metropolitan areas generally have agencies whose mission is to collect information on a wide variety of service providers throughout the community. These agencies, often called Community Information Services, also collect data on alcohol and drug treatment services. They usually can give a caller basic information about the treatment resource such as hours of operation, population served, and how to gain access to such services. Another type of information service that is available to residents of large metropolitan areas is called the Alcoholics Anonymous (AA) Central Office. One function of the AA Central Office is to receive calls from individuals who themselves are asking for help. While these callers generally tend to be adults in crisis, this service is available to adolescents who want help. The AA Central Office also functions to receive telephone calls from professionals who desire information about alcoholism treatment. However, Alcoholics Anonymous does not take a position in support of or against professional treatment services.[1] Alcoholics Anonymous, therefore, is not a source of information about treatment facilities or other services for adolescents. The physician will, however, be able to inquire about those meetings which tend to attract an adolescent population group. Most AA Central Offices publish a directory of all the meetings in their area. These meeting directories are available to any one who is willing to call or write and request them. It is highly recommended that physicians secure a supply of the Alcoholics Anonymous Meeting lists to give to adolescent chemically dependent patients.

Local Alcohol/Drug Planning Agencies

In large metropolitan areas, often there will exist local agencies designed to plan a continuum of services for alcoholism and drug abuse treatment. In smaller communities, mental health centers usually will serve this function. Again, these agencies may be organized separately for alcohol and for drugs, or they may combine the programs. One of the missions of these agencies is to have the latest information on any treatment resource which is available in the community. These agencies also may be identified through public service announcements on television or radio. Another service often provided by local alcohol/drug agencies is a 24-hour hot-line. Through this service, an individual is usually on duty who is able to do crisis assessment and make an appropriate referral for an adolescent in trouble.

Single State Authorities

Each state that receives funds from the Federal Government for alcohol or drug abuse treatment has either a separate or combined division, bureau, or department, which coordinates service provision at the state level. This division, bureau, or department is usually housed in the Health, Mental Health, or Public Welfare Department of the state. One of the responsibilities of single state authorities is to be aware of services that are available at the state level. Many single state authorities publish state-wide directories of alcoholism and drug abuse treatment services; these are available upon request.

The National Council on Alcoholism

The National Council on Alcoholism (NCA) is one of the pioneer organizations created to increase professional and public awareness of the disease of alcoholism in the United States. The NCA has local affiliates in major cities throughout the country; these local affiliates are responsible for providing information about treatment resources. In addition, the NCA publishes a monthly magazine called *Alcoholism,* which is available by subscription. The NCA also publishes a *Guide to Treatment Facilities* which includes those facilities which have paid to be included in the directory. The phone number for a local affiliate of the NCA is available in your telephone directory.

The National Institute on Alcohol Abuse and Alcoholism and the National Institute on Drug Abuse

Both the National Institute on Alcohol Abuse and Alcoholism (NIAAA) and the National Institute on Drug Abuse (NIDA) are located in Rockville, Maryland; they are funded by public money to spearhead national efforts at combating the diseases of alcoholism and drug abuse. Both agencies fund research, education, and demonstration projects designed to improve the capability of treating these primary diseases. The NIAAA also funds an information and referral service to further professional and laymen's understanding of alcoholism.

Both agencies also make available, upon request, directories of alcoholism and drug abuse services in all 50 states. This is a valuable resource, particularly for those physicians with scarce resources in their general vicinity where the likelihood of a referral to an out-of-state resource is high.

Types of Available Services

Several community resources are available to assess the chemically dependent adolescent.

The following describes the continuum of services that is available to the chemically dependent adolescent, the family, and to the physician in search of appropriate resources.

Assessment/Evaluation

There may be times when a physician has discovered data which lead him to suspect that an alcohol or other drug problem exists with an adolescent. However, he may be uncertain whether the data constitute sufficient cause for the diagnosis of chemical dependence and some form of treatment. Therefore, assessment services are often provided within the context of local inpatient treatment facilities. Additionally, outpatient assessment is also available, often through agencies which specialize in intervention. Not to be overlooked, many private practitioners, not necessarily physicians, have become skilled in the assessment and treatment of chemical dependence in adolescents. The physician should not hesitate to make a referral for a third party evaluation when, either due to personal preference or pressure from the adolescent or the family, it seems wise to do so.

Self-Help Groups

There are a variety of self-help groups available to assist the adolescent and the family. For the chemically dependent adolescent, Alcoholics Anonymous and Narcotics Anonymous are available. These groups often have meetings which tend to attract a younger population. The meetings are open to any individual who has a desire to stop drinking or using an addictive substance. Alcoholics Anonymous and Narcotics Anonymous are, therefore, not the referral of choice for the adolescent who has difficulty accepting that alcohol or drug problems exist. These groups almost universally are used as a referral to support the adolescent's recovery after a period of inpatient or outpatient treatment. All self-help groups related to alcohol and drug addiction use the Twelve Steps as the blueprint for recovery. The Twelve Steps[1,2] are:

1. We admitted we were powerless over alcohol (or our addiction)—that our lives had become unmanageable.
2. We came to believe that a Power greater than ourselves could restore us to sanity.
3. We made a decision to turn our will and our lives over to the care of God as we understood Him.
4. We made a searching and fearless moral inventory of ourselves.
5. We admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
6. We were entirely ready to have God remove all these defects of character.
7. We humbly asked Him to remove our shortcomings.
8. We made a list of all persons we had harmed and became willing to make amends to all of them.
9. We made direct amends to such people wherever possible, except when to do so would injure them or others.
10. We continued to take personal inventory and when we were wrong, promptly admitted it.
11. We sought through prayer and meditation, to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as the result of these Steps, we tried to carry this message to others and to practice these principles in all our affairs.

The principles contained in the Twelve Steps are a distillation from the major religions and spiritual thinkers through the ages.[3] The goal of working a Twelve-Step program is internal change by taking an honest and realistic look at the problem, trusting that a Higher Power will assist in recovery, and finally, will help others in the same way.

Self-help groups are similarly available for family and friends of adolescent chemically dependent patients. These groups include Al-Anon, Nar-Anon, and Families Anonymous. The groups are open to anyone who has a relative or friend whose life has been affected by alcohol or drugs. While the methods and principles of recovery are comparable in each of the groups, many families of adolescent chemically dependent individuals find Families Anonymous the most helpful since it focuses

specifically on the discussion of problems dealing with this age group.

A primary objective of self-help groups is to assist family members in dealing with their own problems; that is, the need to overly control, to cover up for, or to reject the chemically dependent adolescent. There is no charge for participation in self-help groups; membership is open-ended and the groups are not affiliated with any religious denomination.

More recently, self-help groups such as Tough-Love have emerged. These groups are not Twelve-Step based; they are designed specifically to assist parents who are having difficulty with problematic behavior of their adolescents. In many cases, the behavior is related to chemical dependency, and these groups are able to support the parents in making very difficult decisions, such as to foster the adolescent's seeking treatment.

Outpatient Treatment

Outpatient therapy tends to be less successful for chemically dependent adolescents due to denial mechanisms and the negative influence of the peer group.

Generally speaking, outpatient treatment is not viewed as the treatment of choice for adolescents who are chemically dependent. Usually for outpatient treatment to be successful, the individual being treated must accept the problem of chemical dependency, be motivated to do something about it, and have significant family support for recovery during the course of treatment.

For adolescents, acceptance of an alcohol or other drug problem is, at times, even more difficult than for adults because they have not yet experienced the harmful consequences which make adult chemical dependency so obvious. Many adolescents, therefore, are particularly resistant to treatment. Their primary group of reference is the peer group rather than the immediate family. For alcohol- and drug-dependent adolescents, this peer group is most often a drinking or using peer group, and one which is not apt to be supportive of an individual's recovery. Adolescents who are attempting to maintain sobriety via outpatient treatment, when exposed daily to these negative peer group influences, often have a great deal of difficulty maintaining sobriety for any extended period of time. However, many outpatient programs offer a variety of support services which are useful for the chemically dependent adolescent and the family. These services include insight groups for adolescents who are not yet ready to enter inpatient treatment in which they can explore with other adolescents in a safe setting their use of mood-altering chemicals. Often family members are asked to attend parallel groups in which they increase their understanding of the disease of chemical dependency and, if necessary, prepare themselves for an intervention into their chemically dependent adolescent's chemical use (View/Discuss Video II). Many outpatient services also provide aftercare for adolescents and their families following a period of inpatient treatment. The specifics of aftercare will be discussed in the section on Inpatient Treatment. These outpatient services are conducted in private practices, agencies, or community mental health centers.

Nonresidential Primary Treatment

For a growing number of adolescents, a diagnosis of chemical dependency can be made, but the medical necessity for inpatient treatment is difficult to document. Medical necessity for inpatient treatment is usually justified if there is evidence of physical dependence, significant family disruption, or other factors which would make maintaining sobriety in a nonresidential setting difficult. For these adolescents and their families, an alternative model of primary treatment is gaining prominence. Called nonresidential primary treatment, all of the services offered in inpatient treatment, including school, can be provided except that the adolescents go home in the evening to their families. This is a less costly alternative to inpatient treatment. Failure to maintain sobriety in an outpatient or nonresidential primary model may also justify the medical necessity for inpatient treatment.

Inpatient Treatment

Inpatient treatment is usually the treatment of choice, when available, for alcohol and other drug-dependent adolescents.

There are typically four phases of inpatient treatment. These include Detoxification, Assessment, Rehabilitation, and Aftercare.

1. Detoxification

The majority of alcohol or other drug-dependent adolescents will not require a period of detoxification upon entering inpatient treatment.

Adolescents generally will not have used a specific drug long enough for physical dependence to have developed. However, in those cases where minor withdrawal symptoms such as anorexia, irritability, or tremulousness are present, the physician needs to be prepared to respond with appropriate detoxification protocols. Table 5-1 summarizes suggested detoxification protocols which can be used when withdrawal symptoms occur. It is very unusual for adolescents to have withdrawal symptoms from alcohol, including delirium tremens. However, you are encouraged to develop an understanding of the management of this serious disorder in which autonomic overactivity, confusion, and hallucinations are prominent. Most often, human contact and reassurance are sufficient for minor withdrawal.[4-8]

Table 5-1. Suggested Detoxification Protocols

Alcohol

1. Nondrug modalities, including reassurance, lighting, soft music, and respect, should be the first step. A benzodiazepine such as Librium (chlordiazepoxide) 25 - 50 mg (po) q2h prn x 48 hours might be used if any withdrawal indicators such as irritability, tachycardia, or restlessness are present. Valium (diazepam) or Serax (oxazepam) may be used just as well in appropriate doses. There is a trend toward favoring the shorter-acting agents in this family of drugs with less hepatic metabolism, such as oxazepam. For example, a patient with signs of withdrawal may require up to 90 mg/day of oxazepam in divided doses.
2. Benzodiazepines should not be given intramuscularly because of poor absorption. The goal is to sedate the patient, not to induce coma. Thiamine, 100 mg daily for 3 days, and multivitamins should be given. Close observation is essential for good patient care. Then continue benzodiazepine therapy.
3. Phenothiazines should be avoided at any stage of alcohol detoxification because they lower the seizure threshold and have other problems. Some physicians presently also have reservations about the use of barbiturates in alcohol withdrawal for safety reasons.

Table 5-1. (cont) Suggested Detoxification Protocols

Barbiturates

1. Phenobarbital (up to 60 mg) q4h if any withdrawal indicators present, not to exceed 360 mg in 24-hour period.
2. Day 2 - repeat phenobarbital dosage of Day 1.
3. Day 3 - if resident stable, decrease daily dosage by 25%.
4. Subsequent days, decrease total daily dosage by 25% each day, if stable.
5. If not stable, maintain on same dose for few more days then begin decreasing dosage by 25%. DO NOT INCREASE DOSAGE.
6. If magnitude of addiction has been overstated in history, toxic symptoms (slurred speech, nystagmus, ataxia) may occur during the first day or two of treatment.

Nonbarbiturate - Sedative/Hypnotics

1. Phenobarbital is the drug of choice for detoxification, if withdrawal indicators are present.
2. The following table is an equivalency list of specific hypnotic/sedatives to phenobarbital:

DRUG	mg	PHENOBARBITAL EQUIVALENT mg
Chloral Hydrate	500	30
Ethchlorvynol (Placidyl)	350	30
Glutethimide (Doriden)	250	30
Meprobamate (Equinil, Miltown)	400-600	30
Methaqualone (Quaalude, Sopor, etc.)	250-300	
Methyprylon (Noludar)	300	30

3. Based on the specific drug used, the suggested Barbiturate Detoxification Protocol should be used.

Benzodiazepines - Sedative/Hypnotic/Tranquilizers

1. Serax 30 mg q4-6h, if any withdrawal indicators are present, until stable, except if the drug used is Ativan or Librium.
2. Decrease Serax dosage daily by no more than 10% of total daily dose.

Table 5-1. (cont) Suggested Detoxification Protocols

3. If Ativan or Librium is the drug used, use the same agent as detoxifying drug in daily decreasing dosages.

Narcotics - Opiates and Synthetics

Large-dose Users

1. For persons on large doses of opiates, with withdrawal indicators present, Clonidine is the drug of choice for detoxification.
   a. 0.2 mg test dose given—monitor vital signs q15 minutes for 1 hour and q1h until next dose.
   b. 0.3 mg given 6 hours later—monitor vital signs q4h until stable.
2. Next six days, the dosage schedule is:
   a. 0.3 mg at 8:00 a.m.
   b. 0.2 mg at 2:00 p.m.
   c. 0.3 mg at NS
3. Next three days, give one-half (½) of total daily dose and then discontinue.

Stimulant

If withdrawal indicators are present, major tranquilizers are relatively specific antidotes for amphetamine intoxication.

Hallucinogens

If withdrawal indicators are present, major tranquilizers may be used.

2. *Assessment*

The purpose of the assessment unit is to determine whether or not a chemical dependence diagnosis is appropriate and to evaluate the need for inpatient treatment.

The assessment unit serves to determine the appropriateness of diagnosing chemical dependence and to evaluate the need for inpatient treatment. If it is determined that chemical dependence is present, the next task of the assessment phase is to convince the adolescent of the diagnosis. This task is frequently much more difficult in the adolescent than in the adult because the adolescent is unable to see how his or her life has been adversely affected by the use of mood-altering chemicals. The typical length of stay in the assessment phase is five to ten days, depending upon the adolescent's progress. Many inpatient treatment facilities for adolescents contain locked assessment units for those cases when the adolescent is angry, afraid, and confused, and not accepting a diagnosis of chemical dependence.

If it is determined as a result of the assessment that the adolescent is not alcohol- or other drug-dependent, the adolescent is then released at this point from treatment. Often, a preliminary assessment is made on an outpatient basis prior to inpatient assessment. Regardless, the involvement of the family and other significant persons is important in the assessment process whether it is done on an inpatient or an outpatient basis.

3. *Rehabilitation*

The rehabilitation phase consists of educational aspects and group therapy, including confrontational experiences. Involvement of the family is crucial.

The rehabilitation phase of treatment usually consists of an educational component via lectures and films and group therapy in which the adolescents confront one another and are confronted by staff about the blocks to recovery which are identified. In adolescent treatment programs, this confrontation is usually much more aggressive than in adult programs. Also, each adolescent is given a small task to perform in support of community living and as a gauge against which to measure the adolescent's emerging sense of responsibility. There are expectations to which each adolescent is required to adhere in order to support community living. Individualized treatment plans are designed for each adolescent. These treatment plans identify the issues in each adolescent which must be overcome in order to begin a life of recovery.

Issues which must be addressed in adolescent treatment often involve other members of the family. For this reason, it is critical in adolescent chemical dependency treatment that family members become involved in inpatient treatment. Part of this involvement is in the form of formal education and family group therapy. It is not unusual as the result of this education and therapy that a parent or other family member is also identified as being alcohol- or other drug-dependent. It is critical that, when this identification is made, the family members are referred for assessment and treatment for their chemical-dependency problem. If chemical dependency in other family members remains untreated, the probability of

the adolescent returning home and maintaining sobriety is very poor.

The goal of the rehabilitation phase is to have the adolescent completely accept the diagnosis of chemical dependency, not only intellectually, but also emotionally; to identify and break any barriers to recovery; and to gain the adolescent's and family's commitment to an ongoing program of recovery. This program of recovery will most often include attendance at self-help group meetings and aftercare following discharge from inpatient treatment.

4. *Aftercare*

Participation in an aftercare program is essential for the recovery process of a chemically dependent adolescent.

Generally, both the adolescent and the family are involved in an extensive aftercare program. Aftercare groups meet during and/or after school. The purpose of the aftercare sessions is to give the adolescent and the family an opportunity to receive support for the very difficult task of re-orientation to the family, to school, and to peers. Aftercare programming usually lasts, with varying degrees of intensity, for up to a year and possibly two years after discharge from inpatient treatment. While inpatient treatment is a relatively secure, drug-free, safe environment, the return to the outside world is fraught with dangers to the adolescent's continuing sobriety. Many studies[9-13] show that the key to ongoing recovery in chemically dependent persons is the extent to which they are willing to become actively involved in ongoing aftercare support, as well as self-help group programming.

Extended Care

More intensive than aftercare programs, which may be considered as a form of extended care, the formally titled extended care program includes prolonged inpatient care, quarterway house care, and halfway house care.

Extended care for chemically dependent adolescents can take any of several forms, each of which refers to a continuation of treatment which is more intensive than aftercare. First, extended care can refer to an extension of inpatient treatment. That is, extending the chemically dependent adolescent's stay beyond the usual course of treatment, which is typically anywhere from 28 to 42 days. This option is usually exercised when there have been more than the usual blocks to acceptance of a diagnosis of chemical dependency, or more than usual resistance on the part of family members to become actively involved in supportive treatment for the adolescent as well as engaging in a recovery program of their own. Other factors indicating the need for an extension of inpatient treatment include concurrent medical problems, usually relatively infrequent in adolescents, as well as co-existing psychiatric or emotional problems which complicate treatment. If the extensions are requested in the same hospital, they are usually limited to seven to ten days and often require prior approval of the insurance provider. If the adolescents are referred for extended primary treatment in another facility, the admission is considered independently and greater flexibility is available with some insurance carriers.

A second option for extended care for chemically dependent adolescents is known as the quarterway house. A quarterway house program is usually highly structured and intensive, similar to inpatient treatment. However, it does not have a medical component and is usually not covered by third-party insurance. The length of stay at a quarterway house may vary from three months to a year, but typically is of six months duration. Chemically dependent adolescents are considered candidates for quarterway house placement when their natural family would be so fractured that a return there would be likely to result in a return to chemical use. It is also indicated when peer group pressure is so strong and the adolescent's commitment to sobriety so weak that relapse would be a likely result. Quarterway house beds are usually very limited because of the lengths of stay. Therefore, assessment of and referral for the need for this type of placement must be made as early in inpatient treatment as possible.

A third form of extended care is known as the halfway house. This type of program is usually less intense than a quarterway house, provides a longer length of stay, and is intended to be a transitional living arrangement between a supportive treatment environment and a chemically dependent adolescent's home, school, and peer group environments.

A final form of extended care is probably better

defined as an alternative home environment for chemically dependent adolescents, that is, the foster care family. Many times after inpatient treatment or quarterway house treatment where adequate halfway house beds do not exist or where the adolescent remains, for whatever reason, unable to return home to his natural parents, placement with a foster family is recommended. More and more frequently, recovering alcoholic adults with many years of sobriety are becoming willing to open their homes to a newly recovering adolescent in order to provide foster care support. The names of families who are willing to be foster parents are often known to the staffs of treatment facilities.

Limitations of the Real World

The preceding discussion has presented an overview of the continuum of care that is possible for alcohol or other drug-dependent adolescents. In actuality, it is very rare that the complete continuum of care exists even in major metropolitan areas or regions of the country. In addition, there are other limiting factors which must be taken into account when exploring treatment options.

Limitations in Services Available

Services designed specifically for chemically dependent adolescents are available in all areas of the country. The role of the physician is to be familiar with community resources in addition to assuring that recovery efforts are being maintained.

A physician is often placed in a very frustrating situation of knowing the type of service which would best meet the needs of the chemically dependent adolescent, and yet not having that service available. Lack of appropriate services alone results in adolescents being inadequately treated or inappropriately treated; for example, being treated as an adolescent psychiatric patient rather than for the primary disease of chemical dependency. A physician must seek to broaden his scope and attempt to locate resources that may not exist in the immediate community. There are some parts of the country that are rich in services for the adolescent chemically dependent patient. Usually, local treatment providers are more than willing to assist a physician in locating services which may not be available in the immediate community.

In those cases where it is not possible to refer an adolescent for services outside the community, the physician may need to do the best he can with what is available. For example, when Alcoholics Anonymous meetings are the only resource available, the physician should attempt to be an advocate on the adolescent's behalf in linking him or her up with those groups and those AA members who may be particularly sensitive to the needs of adolescents. The physician is well advised to see the adolescent on a regular basis in order to assess progress and encourage a smooth transition into self-help group recovery. If the adolescent has difficulty integrating into self-help group programming or has difficulty continuing to abstain from mood-altering chemicals, the physician must look at other alternatives.

When hospitalization is determined to be necessary and it cannot be done in a program specifically designed for inpatient treatment of the chemically dependent adolescent, the physician must do everything possible to ensure that the primary problem of chemical dependence is recognized and treated. Specific suggestions include consultation with the admitting physician, if it is one other than self; making available to the adolescent as a part of the treatment plan literature specific to adolescent chemical dependence; encouraging visitation from members of Alcoholics Anonymous, particularly other adolescents with whom the person may easily identify; and continuing education of the family members regarding adolescent chemical dependence, as well as their own recovery.

The best option is for physicians to become personally knowledgeable of the treatment of chemical dependence in adolescents. When one person, even in a small community, develops a special interest in this area, the amount of interest and support which is generated is pleasantly surprising.

Limitations in Family Support for Treatment

The physician must try to obtain cooperation from family members for the treatment process. This can be difficult since some family members may drink themselves or be embarrassed that their loved one has an abuse problem.

It is not infrequent for the physician to face the situation where the adolescent may be accepting of the need for help, but the family members may be unable or

unwilling to support the adolescent in a recovery program.[14] The causes for such unwillingness and inability are understandable and are often based in common stereotypes about chemical dependence, fear, pride, or embarrassment at having chemical dependence identified in one's own family (View/Discuss Video IX). An additional factor which is a major cause of family resistance is the unidentified chemical dependence of another family member. This is usually a parent who subconsciously realizes that treatment of the adolescent's chemical dependence would demand that his or her use of chemicals also will need to be challenged and dealt with. In order to deal with resistances in family members, several strategies are helpful.

First, the physician should be very up-front with all members of the family that the use patterns of all family members are significant to the recovery of the adolescent. A routine alcohol and drug history should be taken on each family member and discussed with the family. Where a problem is identified in more than one family member, each family member affected by the disease needs to be referred to appropriate treatment.

Second, listen to the pain in the family. It is important that all family members be allowed to talk about their feelings toward the chemically dependent. Many family members spend countless hours with chemically dependent adolescents, doing their best to help them stop. In spite of their best efforts, they have met with failure. They may feel frustrated, bitter, and defeated. They may feel that their adolescent is bad and will never amount to anything. They may also feel that the adolescent is using drugs or drinking specifically to hurt the family to get back at them for something they might have done. Many family members fear what others will think of their family if chemical dependence is identified in one of its members. Will they lose friends? Will the neighbors gossip? How will their lives be changed? The physician must patiently listen to the feelings that are expressed by family members, allowing the healing process in the family to begin. Often this healing requires education of the family about chemical dependence, the disease concept, and how all family members are affected. It involves encouraging each member of the family to embark upon a personal program of recovery and the willingness to continue meeting with the family whose resistances do not disappear quickly.

Third, the physician may need to be an advocate for the needs of the chemically dependent adolescent. If in spite of all his best efforts the physician continues to meet with significant family resistance, he may need to proceed with advocating for treatment in spite of the resistance. This involves the risk of alienating the family, but the danger of untreated chemical dependency in an adolescent must be weighed against this risk.

Limitations in Financial Resources

The physician should be an advocate for the family if financial limitations affect the capability of the young patient to get proper treatment.

The physician will face the situation where the chemically dependent adolescent is willing to accept help, the family is supportive, but sufficient financial resources are not available for treatment. Most insurance carriers cover inpatient chemical dependence treatment. More recently, outpatient treatment has been recognized by the insurance industry as a less costly form of treatment and is being covered. However, many families do not have the benefit of such comprehensive insurance coverage and therefore are faced with the reality of not being able to afford treatment. Often the physician will be faced with the decision of whether to put the time into working with the chemically dependent adolescent and the family that the situation demands without receiving full financial compensation for all the time that will be necessary to invest. The decision of how much free or partially reimbursed care to give is one which can be made only by an individual physician.

In the physician's role of advocate for the chemically dependent adolescent, he must be creative in seeking financial resources for the adolescent. In some areas, there are welfare-funded programs for adolescents. In others, rehabilitation and disability resources may be used for the benefit of the chemically dependent adolescent. At times, inpatient treatment centers are willing to give indigent care on a limited basis. In this respect, it would behoove the physician to establish personal relationships with chemical dependence treatment personnel and to become an advocate for their efforts. In spite of these efforts, it is clear that adolescents whose families do not have health insurance do not have access to the same quality of services as those whose families are fortunate enough to be insured.

Patient-Specific Needs Assessment

The next job for the physician is to gather sufficient data from both the adolescent and the family in order to

make the best possible referral of the adolescent and family to treatment resources. Appendices A and B give an interviewing format which will assist the physician with this data collection.

Choosing the Right Treatment Resource

The physicians in the community should familiarize themselves with the available treatment centers to learn the methods, strengths, and weaknesses of each.

Let us assume for a moment that your community is blessed with a variety of treatment resources and that there are several inpatient programs for adolescents from which to choose. How does the physician know which of these might be best for an adolescent who is chemically dependent? While this is not an easy question to answer, there are guidelines to give the physician some assistance in making this decision.

First, check the facility's track record. Find out what type of reputation it has in the community, who else tends to use it, and how other adolescents have done who have gone through the program. Another useful indicator is what the census has been over the past twelve months. While census data can be a function of public relations, it can also be an indicator of the confidence that other referring sources in the community place in the particular facility's ability to do a good job.

Second investigate the facility yourself. Call and ask for an appointment; ask them for one of their brochures. When you visit the facility, try to put yourself in the place of the adolescent whom you will be referring there. Try to obtain the kinds of information that you will need to communicate to the adolescent and the family. Find out information such as the hours of admission, the admitting procedure, the length of the program, and so forth. Find out whether there is an initial phase of treatment in a locked unit or whether the initial treatment is in an open unit. This is crucial to know, particularly when adolescents are not willing to enter treatment of their own volition. Find out to what extent the family is asked to be involved in treatment. If family members are not directly involved in therapy with the adolescent to some degree, then you may want to investigate other alternatives.

Find out what their aftercare program consists of. Are both the adolescents and family members involved in aftercare? For how long? Is aftercare built into the per diem rate, or are there additional charges for aftercare? Try to meet as many staff members as possible and get a sense for the degree to which they are able to be loving and supportive and yet, at the same time, firm with an adolescent. Find out what their groups are like and what their educational program consists of. Ask for a copy of their daily schedule; ask what their philosophy is toward the use of the Twelve Steps of Alcoholics Anonymous and the degree to which the steps become a part of the treatment experience. If there is something that you do not like, do not hesitate to ask about it. Remember, you are placing patients and their families in the care of this treatment program. You have a right to know.

Another option for the physician is to try a facility and see how it works. Many times this may be the only option available to a physician, particularly if the facility is new. Some things to look for are how open the facility is to sharing information with the referring physician. Some treatment facilities operate like a black box. That is, you put the adolescent in treatment, and you never hear from the treatment facility until the person is discharged. You have no idea of the progress that was made in treatment, of the barriers to recovery that the adolescent experienced, or of the work that may need to be done by you when the adolescent is discharged.

Most treatment facilities are very willing to work with the referring physician and to keep the physician informed via weekly telephone calls or summaries of the adolescent's progress. Some are willing to let the physician be involved in discharge and after care planning. At the minimum, a physician should request to receive a copy of the discharge summary which outlines the course of treatment. One final word about treatment centers—they often go through natural cycles of strengths and weaknesses. Their strengths at any given time may depend upon such factors as the number of new patients in the treatment facility, the number of strong peer leaders who have been recently discharged, the number of new or inexperienced staff members, and the financial stability of the program or the overall parent institution in which it is housed. Also, remember that no treatment facility can ever be 100 percent successful. A healthy program is one that is able to openly discuss its strengths and limitations with the referring physician and help the physician decide whether or not it may be the best possible resource for a given adolescent.

Physician Issues

In addition to the practical details surrounding referral and treatment of the chemically dependent adolescent, there are some very real individual and personal issues that each physician must consider that will impact on his ability to address the needs of a chemically dependent adolescent.[15-17]

Do I really believe that chemical dependence is a disease and that it is treatable?

Some physicians do not believe that chemical dependency is a disease. However, most professionals in the field believe that treatment based upon the disease model works better than that of other models.

Many physicians have difficulty understanding that adolescents can be chemically dependent. They feel that, because of their age, much of what is seen symptomatically is a part of adolescent acting-out behavior and that adolescents will grow out of it as they mature. Other physicians view chemical dependence as a moral problem rather than as an illness. This view would see chemically dependent adolescents as bad kids and that all they need to do is straighten up. If they had sufficient willpower or direction, they would be able to conquer the problem without help from outside sources. Still, others view chemical dependence as a symptom of other underlying conditions and not as a primary disease. These physicians would tend to treat chemical dependence psychiatrically, thereby enabling the adolescent to avoid facing the reality that the chemical use must stop as a prerequisite for improvement in other life areas. Finally, many physicians doubt whether chemical dependency is treatable. Their doubts are based upon their experiences, very often with late-stage chronic alcoholics or drug abusers whose prognoses are poor and whose family and community supports are practically nonexistent.

If we truly accept that chemical dependence is a primary disease, then we must also treat it as we do other primary diseases. This means that, generally speaking, the earlier we intervene in the progression of the disease, the more quickly it will be arrested, and more suffering will be avoided by both the adolescent and the family. The policies of many government funding agencies and insurance carriers do not indicate that there is deep conviction on their part about chemical dependence being a primary disease. Whether you as an individual physician believe or do not believe that chemical dependence is a disease, the consensus of professional opinion at this point indicates that treating it as if it were works more effectively than treating it as if it were not.

To what extent do I want to get involved in the treatment of adolescent chemical dependence?

Each physician must determine his or her own commitment to involvement in the treatment of chemical dependency. All primary care physicians should be comfortable with the process of detecting and diagnosing chemical dependency.

The answer to this question is a very individual one and can only be made by each physician after consideration has been given to his personal commitment to this field. There are several different levels of involvement possible. The most basic commitment that each physician must have to this disease is its detection and diagnosis. All adolescents and their families deserve to have physicians who are knowledgeable about the signs and symptoms of adolescent chemical dependence. Once a physician has determined that chemical dependence may be a problem, he has the choice of referring that adolescent to a colleague who specializes in chemical dependence or to an agency or program that can further assess the adolescent and determine the type of treatment that would be most appropriate.

Some physicians prefer to be able to do a more in-depth evaluation themselves and to become personally knowledgeable of treatment resources within their community. These physicians will want to take the time to investigate facilities according to the guidelines specified in the preceding sections.

Some physicians may choose to become personally knowledgeable of the dynamics of chemical dependence treatment at the individual and family levels, perhaps even to the point of working with a chemical dependence treatment unit. Physicians who desire this level of involvement will need to be involved in an internship or a training program specifically designed to educate them about chemical dependence treatment. They will want to become knowledgeable of literature in the area of chemical dependence, to have experienced Alcoholics

Anonymous and Al-Anon or Families Anonymous meetings, and to spend time learning from their adolescent chemically dependent patients and their families. There is nothing more rewarding than having chemically dependent adolescents and families come back and express gratitude for having been identified and intervened early on in the course of the disease.

Each physician will need to identify his own comfort level with each of these types of involvement, his willingness to invest the time needed to become knowledgeable of each facet of chemical dependence treatment in adolescents, as well as his willingness to investigate his or her own use of mood-altering chemicals.

How do I support the adolescent, the family, and the treatment team in their recovery efforts?

The young patient needs the continued encouragement of the physician during the time-consuming recovery process.

Change is not easy for anyone. It is even more difficult for an adolescent who may have difficulty seeing that a chemical dependence problem exists and for a family who questions the need for ongoing involvement in a recovery program. Adolescents may complain to their referring physician that their counselor is being too tough in his demands and question the necessity of so many meetings. It is important that the physician support the treatment team in the efforts at guiding the adolescent and the family toward recovery. In early recovery, particularly, it is important that adolescents involve themselves in an intensive program of support, even after release from inpatient treatment. The intensity of this involvement will need to be balanced against the demands of school, family, aftercare, and recreation. It is rare that a newly recovering adolescent can work an effective program of recovery with less than three or four AA meetings a week. (View/Discuss Video VIII) The physician can listen sympathetically to the adolescent's complaints about not having adequate time for social life, but remind the adolescent that, at this point, sobriety must be the most important priority and that once a strong recovery program is in place, most other aspects of normal adolescent life will fall into place.

How do I handle an adolescent/family who does not follow treatment recommendations?

When the adolescent does not follow the treatment recommendations, the physician must make individual decisions about the future of the doctor-patient relationship.

The answer to this question is a difficult one and must be given on a case-by-case basis. However, there are some general principles that can guide a physician in making these decisions. First, it is important that you maintain a positive relationship with the adolescent and the family. If you are the only physician with whom this person has a positive therapeutic relationship, then it may be in the adolescent's best interest for you to take a more supportive role. This does not mean that you will not confront the adolescent, but you may be able to do it more gently over a longer period of time. You would also want to avoid giving messages such as, "If you don't follow my recommendations, I won't see you again." While such messages are sometimes helpful and necessary, in the case of a physician who is playing a supportive role, they are inviting the adolescent to put you in a no-win situation. If more supports are available, being more directive is advisable.

Another factor which must be considered is the severity of the progression of the adolescent's disease. If the adolescent has deteriorated to the point where he is a potential danger to himself or others and where the family is in total disarray, it is incumbent upon the physician to take a very firm stand and insist that chemical dependence treatment be undertaken. This must be done by the physician even when the risk is high that the adolescent may choose not to see the physician again. The physician will be planting a seed that may bear fruit later in the adolescent's life. The adolescent will also know that someone cared enough to be totally honest in spite of personal risk of rejection. Many adolescents are grateful for this type of intervention even though they are unable to show their gratitude at that particular moment.

How do I handle a relapse after treatment?

Relapse is not unusual in alcoholism or other chronic diseases. Your response will depend on the situation, but do not assume a negative outcome.

Because chemical dependence is a chronic disease, the probability of relapse is high. Many physicians view relapse as a personal failure, a failure of the treatment center, or a failure on the adolescent's part to meaningfully engage is a recovery program. Such blame of self or others is not helpful and can lead to an unsuccessful resolution of the problem at hand. If handled properly and detected early, a relapse can be a very positive experience.[18]

Many times adolescents leave treatment not being fully convinced that they are chemically dependent, that they are powerless over mood-altering chemicals, or that their lives are unmanageable. They may be able to verbalize that they are chemically dependent but not yet be fully accepting of the fact. In these individuals, a relapse may signal their attempt to prove that they can use mood-altering drugs safely. When they find that they cannot, the education and therapy they received in treatment may begin to make some sense. Other cases of relapse may mean that the adolescent is having difficulty coping with the pain of a sober life, that the pressure of the peer community is too great to resist, or that there is a missing element to the recovery program. The adolescent may be trying hard to stay sober, but something is just not working. In these situations, it is wise to refer the person to a professional in chemical dependence in order to get an evaluation of the adolescent's needs. In some cases, a return to treatment will be indicated. In other cases, adjustments in the adolescent's ongoing recovery program will be sufficient. In either case, it is important for the adolescent to know that the physician will be there in a nonjudgemental and supportive role.

Summary

This unit of study has given some practical guidelines concerning referral and treatment of chemically dependent adolescents and their families. It has described an ideal continuum of care, ranging from initial assessment and evaluation to extended care options. It has discussed some of the limitations of the real world that prevent physicians from exercising all of the options available in the best of all possible worlds. It has also discussed issues specific to the physician relating to referral and treatment of chemically dependent adolescents. One additional bit of reality testing that must be stated at this point is that the science of chemical dependency treatment, particularly in adolescents, is very young. Much remains to be learned. This unit of study has attempted to convey some of the latest thinking. It is hoped that this information will stimulate readers to further invest their time and energy in learning more about this topic which is crucial to adolescents.

Evaluation

These activities are proposed to assist you in evaluating your successful completion of this unit of study. As you undertake these activities, involve your colleagues and specialists in the care and treatment of adolescent alcoholics and their families.

Activity 1. Prepare a listing of local resources for:

A. The inpatient and outpatient treatment of adolescent alcoholics and drug abusers.

B. The care and support of families of adolescent alcoholics and drug abusers.

C. The aftercare of adolescent alcoholics and their families.

Activity 2. Maintain a log of facilities and persons to whom you refer adolescents and their families. In this log note such things as cost, insurance acceptance, successes and failures, and the attitudes of adolescents and their families concerning the persons or facilities you use. This log will assist you in developing effective treatment and referral processes.

Activity 3. Arrange for or participate in a roundtable discussion with colleagues and specialists in treatment and referral of adolescent alcoholics. Use this roundtable as a forum to discuss available services, means of utilizing those services, and your personal and community attitudes toward the treatment and referral process. (Note: minutes from this discussion may make ideal material for a public service article to appear in the local press; explore this possibility and invite the press if necessary).

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Appendix A

Preassessment Interview Guidelines

Considerations

1. Need to be in touch with own attitudes/values first (moral issue vs. illness).
2. Need for further evaluation is made primarily by obtaining a history of any consequences that result from drinking. Consequences reflect the seriousness or the degree of the problem. They include symptomatic drinking behavior, psychological involvement, problems with family, friends, jobs, police, health, and finances. Various questionnaires have been prepared to elicit information; they serve best as an interview guide rather than format (see Appendix B).
3. Take time building trust/rapport before asking questions about chemical use. Selected informal questions will help to clarify patient's value system (e.g., ask about leisure time).
4. You will need to ask questions, but do not interrogate.
5. People fear that:
   a. You are going to take something away.
   b. You are going to try to change them.
6. Anyone with a certain amount of dependency (on chemicals, another person, etc.) will be on the defensive. They may become hurt and scared as you start the questions about chemical use or their behavior in relation to chemical use (their own or a family member's). This may lead to anger or blaming.
7. The risk of being judged and punished blocks honesty.
8. Counseling/interview goal is to help people from going on the defensive; use active listening (nonjudgemental). Need to constantly separate the person from the behavior (again, own attitudes and values important).
9. Eye contact important. Also, pay attention to nonverbal responses, incongruencies (e.g., you say you're angry and you look very sad) . . . use feelings, hunches.
10. Remember, the purpose is to gather information and assess, not a therapy session. (When you start doing both at once, it gets crazy.)
11. Don't use the terms "alcoholic" or "chemically dependent." Refrain from answering "yes" or "no" to questions from patients as to whether they or family members are alcoholic in your opinion.
12. In obtaining a drinking history and information about current problems, Jon Weinberg *(Interview Techniques for Diagnosing Alcoholism,* Hazelden Press) suggests:
    A. Nonjudgemental acceptance—Need to accept that "the denial system is an intrinsic part of the illness."
    B. Directness—Ask specific, factual questions "reflecting possible adverse behavioral consequences of drinking."
    C. Persistence—Patient may sidestep question with assurances that there's no real problem (remember, denial, minimizing, alibis, etc. are part of the illness). He often tells irrelevant anecdotes about self or someone. You may need to ask same question again.
    D. Never discuss alibis. Patient may try to explain away circumstances and consequences, blaming, justifying, etc. Move on: "We can come back to that later on, but . . ." Don't reinforce alibi or argue with the patient.
13. Jot down significant direct quotes. Assessment is based on statements and observable behavior.
14. It is useful to make feedback statements (harmful consequences/contrast with value system) as you summarize the interview with the patient. Show care and concern. Ask (this is an offering, not confrontation in the harsh sense).
15. What have you thought to do? What do you want to do?
16. "Based on these statements (be specific), it appears that you're having significant problems in some areas of your life which may be associated with your chemical use (or attempts to control someone else's chemical use)." "I think you would benefit from more information/evaluation." "You're asking many questions which indicate concern for self/other." "You have a right to more answers for yourself. Encourage—give patient credit for openness, etc. Let patients know they've taken an important, big step (its a good motivator).

Appendix A (cont)

17. Become familiar with community resources in order to best match patient individual needs with available services (give options).
18. If patient is ready, he/she can set up an appointment with another agency from your office, or get a verbal commitment: "When do you plan to call?"
19. This is often a process which takes several interviews after the initial intake. However, the client may not return. Open invitation. May return much later.
20. There are no failures, even if the client chooses not to take action at this time or doesn't return. As Weinberg states, "That tiny chip in the denial system may someday make another professional's job a bit easier or otherwise help the client eventually face reality."

Appendix B

Preliminary Assessment Interview (For Adolescents)

I. *School Performance* (changes in relation to any of the following areas over the years)

A. Grades
B. School attendance
C. Extracurricular activities
D. Behavior
E. Status within school
F. Self-evaluation of school performance.

(The following sections contain suggested questions to gather the kind of data which is useful in assessment. This is an interview guide, rather than a format. A lot of this information will come out if you ask students to list their problem areas or "biggest worries." From there, the interviewer can use some of the following questions to clarify.)

II. *Personal Relationships*

A. Family (demographics)

1. Sibling relationships and birth order (survival roles?)
2. Parent relationships
3. Drug use in family (are you concerned about the alcohol/drug use of anyone in your family?)
4. Consequences of inappropriate behavior (What kind of discipline is used?)
5. Do you feel loved? How do you feel?
6. What have you been like to live with for the past six months? How do you feel about that?
7. Status within school
8. Self-evaluation of family relationships (Violence? Anything going on sexually in your family that shouldn't be that you're worried about?)

B. Peer Relationships

1. What do you do for fun? (What did you used to like to do in 4th, 5th, and 6th grades?)
2. What do you do that makes you feel good?
3. Do you know of anybody at school who has a drug problem? Describe (will often be telling about themselves).
4. Do you know of anyone who has stopped using? Do you like them?
5. Do you have any significant relationships with the opposite sex? What's he/she like? (Will often describe self.)
6. Status with peers. Have you changed peer groups in the past two years? (Parents, do you like their friends?)

III. *Drug Use* (don't zero in on this; it will come out indirectly in relation to other areas)

1. First used—what and when (how old were you? . . . Later: "Sounds like with this many problems, you had to start in 4th or 5th grade. Right?)
2. Drug of choice—reason? (Just expect that this table is filled with every drug possible.)
3. Drug most used—reason? (May not be drug of choice.)
4. Pattern of use/changes
5. Tolerance (Establish frequency and amount when first started and now. Kids' tolerance change (drop) doesn't occur. "You're a big kid, I'll bet you can put away a "case.")
6. Blackouts (Does it ever happen that . . .?)
7. Harmful consequences/contrast with value system
   a. Trouble with police (Were you high?)
   b. Changes in personality/behavior (acts of violence)
   c. Trouble at home because of use
   d. Feelings of guilt/depression (Ever thought of just giving up? Of hurting yourself?)
8. Attempts to stop using. How many times? How long?
9. Help. Have you ever talked to anyone about these problems? Family counseling? Agencies involved?

IV. *General Questions*

1. Have you held a job?
2. How do you get your spending money?
3. What do you do with your money?
4. Where do you want to be five years from now?
5. How would you like to be different?
6. What would you like to have done different in your life so far?
7. What do you like most about yourself?

8. What do you hate most about yourself?
9. How do you feel about being here? (Good first question)

Summary

1. How do you see denial working in this person?
2. Did you hear the client blaming others for his situation?
3. If student does not verbally respond to questions, then it is necessary to bring parents in.
4. Assessment is based on statements and observation; state plan (e.g., insufficient data—watch; assign to in-school group; refer for further evaluation).

More on Interviewing

REMEMBER TO: Constantly separate the person from the behavior. Take time building trust/rapport before asking questions about chemical use (maybe 20 minutes). You will need to ask questions, but not interrogate. Youth fear that (1) You're going to take something away, or (2) You're going to try to change them. Anyone with a certain amount of dependency will be on the defensive. Youth may become hurt and scared as you start with questions about their use. This may lead to anger/blaming. The risk of being judged and punished blocks honesty. Counseling Goal: Keep youth from going on defensive. Use active listening (nonjudgemental).